Prescription Drug Reimbursement Claim Form

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

» Instructions: Please read carefully or claims may be denied.

Save time and money. In the future, present your Blue Cross Blue Shield of Michigan ID card at a participating pharmacy and ask them to submit your prescription claim electronically. We have over 50,000 pharmacies in our network.

Submission Requirements

- Claims must be submitted within one year of the date of service. Claims over one year will not be reimbursed.
- **Pharmacy receipts are required for each prescription.**
  - Cash register receipts are not accepted.
  - If you don't have a pharmacy receipt, ask your pharmacy to provide one to you.
- The following information is required to process your claim.
  - Refer to your pharmacy receipt or contact your pharmacy for missing information.
    - ☐ Patient name and date of birth
    - ☐ Prescribing physician name and NPI number
    - ☐ Pharmacy name, address and telephone number
    - ☐ Date of service
    - ☐ Prescription number
    - ☐ Name and strength of prescription dispensed
    - ☐ National Drug Code (also referred to as NDC)
    - ☐ Quantity
    - ☐ Day supply
    - ☐ Amount paid

General Instructions

1. Complete this claim form if you paid full price for a prescription and the pharmacy did not submit a claim to Blue Cross or if you are submitting for Coordination of Benefits.
2. Complete a separate claim form for each patient and for each prescribing physician and/or pharmacy used.
3. **Include a pharmacy receipt for each prescription submitted for reimbursement.**
4. Read the acknowledgement carefully and sign and date the claim form. A signature is required to process your claim.
5. Return the completed claim form and pharmacy receipt(s) to:

   Express Scripts

   ATTN: Commercial Claims

   P.O. Box 14711

   Lexington, KY 40512-4711

   Or you may fax your claim form and pharmacy receipt(s) to: **608-741-5475**.

   Please do not combine claims for different patients in the same fax submission.
6. For more information, call the Customer Service number located on the back of your Blue Cross Blue Shield of Michigan ID card.

EXPRESS SCRIPTS®

Express Scripts is an independent company that provides pharmacy services for Blue Cross Blue Shield of Michigan.

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» Foreign Prescriptions

You may qualify for a vacation supply of your prescription prior to traveling outside of the United States. For more information, call the Customer Service number located on the back of your Blue Cross Blue Shield of Michigan ID card.

Foreign Prescription Requirements

- Medication purchased outside of the United States must have an FDA approved American Equivalent to be considered for reimbursement.
- Medication purchased and shipped to you from a pharmacy outside of the United States will not be reimbursed.
- Claims must be submitted within one year of the date of service. Claims over one year will not be reimbursed.
- **Pharmacy receipts are required for each prescription.**
- The following information is required to process a foreign claim.
  - ☐ Patient name and date of birth
  - ☐ Pharmacy name, address and telephone number
  - ☐ Date of service
  - ☐ Name and strength of prescription dispensed
  - ☐ Quantity
  - ☐ Day supply
  - ☐ Amount paid
  - ☐ Country
  - ☐ Currency used

» Coordination of Benefits Instructions

If Blue Cross Blue Shield of Michigan is your secondary prescription drug plan, complete the following steps for consideration of payment.

1. The claim must first be submitted to the primary prescription drug plan for consideration of payment.
2. Once the primary plan has processed the claim, complete this claim form.
3. Provide your secondary Blue Cross group number and enrollee ID in the Cardholder Information section.
4. Check the box for “Another health plan paid a portion” in the Coordination of Benefits section.
5. Attach the Explanation of Benefits (EOB) statement from the primary plan. The EOB statement should clearly indicate the cost of the prescription and what was paid by the primary plan. If the primary plan didn’t provide an EOB statement, attach the pharmacy receipt. An EOB or pharmacy receipt is required to process your claim.

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Complete the front and back of the claim form and include pharmacy receipts.
Claims may be denied if incomplete.

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Cardholder Information *(refer to your Blue Cross ID card)*

Check your RxGrp ☐ BCBSMRX1 ☐ BCBSMAN

Group Number

Enrollee ID (last nine numbers only)
Example: ABC123456789

Enrollee Name: First Last

Street Address

City State ZIP

Daytime Telephone (including area code) ___-___-____

Patient Information

Patient Name: First Last

Patient Date of Birth (MM/DD/YYYY) __/__/____

Prescribing Physician Information

Name of Prescribing Physician

NPI (National Provider Identifier)

Pharmacy Information

Name of Pharmacy

Street Address

City State ZIP

Telephone (include area code) ___-___-____

Is this an on-site nursing home pharmacy? ☐ **Yes** ☐ **No**

Pharmacy receipts are required for all claims. See back of the claim form for details.

Check the appropriate box if your claim is for:

☐ **Allergy Serum**

☐ **Compound Prescription**
Ask your pharmacist to complete the Compound Prescription section on the back of the claim form.

☐ **Foreign Prescription**
Medication purchased outside of the United States must have an FDA approved American Equivalent to be considered for reimbursement.

Please indicate:

Country _____

Currency used _____

Coordination of Benefits

Indicate the group number and enrollee ID of your secondary coverage.

Check the appropriate box below.

☐ Another health plan paid a portion
(refer to Coordination of Benefits Instructions)

☐ Discount card or coupon was used

Acknowledgment

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any materially false, deceptive, incomplete, or misleading information pertaining to such claim may be committing a fraudulent insurance act, which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment or denial of benefits.†

I certify that the medication(s) described was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I certify that the medication(s) described were not for an on-the-job injury. By completing this form, I recognize that reimbursement will be paid directly to me and that assignment of these benefits to a pharmacy or any other party is void.

X _____ _____

Enrollee or Patient Signature - (REQUIRED) Date

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Pharmacy Receipts are REQUIRED

Include a detailed pharmacy receipt for each prescription. If you don't have a pharmacy receipt, ask your pharmacy to provide one to you.

- Cash register receipts are not accepted.
- Claims must be submitted within one year of the date of service.

Complete the claim information below. All fields are required to process your claim.
Refer to your pharmacy receipt or contact your pharmacy for missing information.

	Date of Service MM/DD/YYYY	Prescription Number *If submitting a foreign prescription, leave this field blank.*	Prescription Name & Strength	National Drug Code (11-digit NDC) *If submitting a foreign prescription, leave this field blank.*	Quantity	Day Supply			Amount Paid
						30 Day	90 Day	OTHER (specify)	
1									
2									
3									
4									
5									
6									

COMPOUND PRESCRIPTION ONLY

- Submit one claim form per compound prescription.
- List a valid 11-digit NDC number for each ingredient in the compound.
- Indicate the metric quantity (number of tablets, grams, milliliters, etc.) for each NDC.
- Indicate the ingredient cost for each NDC.
- Indicate the amount paid for the compound prescription.
- Include a detailed pharmacy receipt with this claim form.

Prescription # ______________

Date of Service __/__/____ Quantity ____ Day Supply ___

Ingredient NDC Number	Metric Quantity	Ingredient Cost

Amount Paid ________

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† **California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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